



Dear Friends,

An important part of being the Insurance Commissioner of the State of Montana is working to keep the public informed on all relevant issues. That is why my office is providing this Glossary of Terms to help with any confusion you may have when it comes to health insurance in Montana.

Please do not hesitate to contact my office with any questions you have about the following definitions.

Sincerely yours,

***Montana Commissioner of Securities and Insurance
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GLOSSARY OF TERMS AND ACRONYMS

Below are definitions for some of the commonly used terms and acronyms relevant to the Patient Protection and Affordable Care Act, the proposed Montana Health Insurance Exchange, and health insurance in general.



A

Actuarial justification — The demonstration by an insurer that the premiums collected are reasonable, given the benefits provided under the plan or that the distribution of premiums among policyholders are proportional to the distribution of their expected costs, subject to limitations of state and federal law. PPACA requires insurers to publicly disclose the actuarial justifications behind unreasonable premium increases.

Adjusted community rating — A way of pricing insurance where premiums are not based upon a policyholder's health status, but instead spreads the risk across a single risk pool, which may represent an entire market segment, such as all individual coverage or all small employer group coverage. Differences are allowed based upon factors other than health status, such as age and geographic location. PPACA requires the use of adjusted community rating in the individual and small employer group market, with maximum variation for age of 3:1 and for tobacco use of 1.5:1.

Adverse Selection — A term that refers to a problem created when only people with significant risk exposure (such as major health issues) will buy a health insurance product. Insurance companies try to minimize the impact by trying to measure risk and to adjust prices they charge for this risk and also by attracting healthy people to the risk pool, instead of just “sick” people.

Annual Cap — Also known as the “out-of-pocket limit.” This term should represent the maximum amount that a consumer will pay of his/her own pocket for that plan year. This would include the total amount paid for deductibles and coinsurance, but not for amounts that are paid as a result of “balance-billing” Some insurers do not include the deductible in the “out-of-pocket limit.” This limit for high-deductible health plans sold with Health Savings Accounts (HSA's) in 2011 may not exceed \$5,950 individual/\$11,900 family. The limitation on cost sharing is indexed to the rate of average premium growth and is changed every year by the Treasury Department.

Annual limit (or Annual Benefit Maximum) — Many health insurance plans place dollar limits upon claims for particular services that the insurer will pay over the course of a plan year (i.e. physical therapy). PPACA restricts annual limits to a certain dollar amount for essential benefits for plan years beginning after Sept. 23, 2010. Beginning in 2014, annual limits on essential benefits are not allowed.

B

Balance billing — When you receive services from a health care provider that does not participate in your insurer's network, the health care provider is not obligated to accept the insurer's payment as payment in full and may bill you for the "overcharge," (i.e. the billed charge that is over and above the amount that insurance company "allowed" for the service provided.) This is known as "balance billing."

Basic Health Plan—Beginning on January 1, 2014, PPACA allows states the option of establishing a Basic Health Plan as an alternative to providing coverage through the exchange for certain individuals. Specifically, the plan would provide coverage to individuals with incomes from 134 percent to 200 percent of the FPL who do not qualify for Medicaid or have access to employer-sponsored coverage. The persons receiving coverage under a Basic Health Plan also must otherwise have been eligible for coverage through the exchange. If the state chose this option, it would contract with plans that provided a specified level of benefits and met cost-sharing limits, and these plans would be offered as choices to Basic Health Plan enrollees. The contract negotiations would have to consider such factors as the extent to which plans engaged in care coordination and had other attributes of managed care. If the state meets federal requirements for the establishment of this program, the federal government would transfer to the state 95 percent of the funds that would otherwise have been available to the individuals eligible for the Basic Health Plan as premium and cost-sharing subsidies to purchase coverage through the exchange. These funds would be deposited into a trust fund and could be used to enhance benefits and reduce cost sharing for those enrolled in the Basic Health Plan.

Broker —In Montana this individual is known as an "insurance producer," a licensed agent appointed by an insurance company who helps businesses and individuals obtain a health plan. A producer "sells, solicits and negotiates" insurance for the companies that they represent.

C

Catastrophic Health Insurance - A high deductible, low premium health insurance policy that is not providing a bronze, silver or gold or platinum level of coverage. Inside the exchange, only an individual under age 30 or individuals who are exempted from the individual responsibility requirement for affordability reasons can purchase these products.

Certified Health Plans - The exchanges will certify "qualified health plans" that will be offered through the exchange. Certification will be based upon the plan's ability to meet federal and state requirements regarding: (1) actuarial value (2) the essential benefit package, (3) marketing practices, (4) provider networks, including community providers, (5) plan activities related to quality improvement, and (6) the use of standardized formats for consumer information.

Child-Only Plan – An individual health plan that is offered to a child, as a stand-alone policy, as opposed to a policy issued to parent or other adult under which the child is added as "dependent." Any qualified health plan offered under the exchange must also be available as a plan available only to individuals who have not attained the age of 21.

CHIP— The Children's Health Insurance Program (CHIP) provides coverage to low and moderate income children. In Montana, this program is known as the "Healthy Montana Kids Program" [HMK]. Like Medicaid, it is jointly funded and administered by the states and the federal government. It was originally called the State Children's Health Insurance Program (SCHIP).

CMS – The Centers for Medicare and Medicaid Services.

COBRA coverage — Congress passed the Consolidated Omnibus Budget Reconciliation Act (COBRA) health benefit provisions in 1986. COBRA provides certain former employees, retirees, spouses, former spouses and dependent children the right to temporary continuation of health coverage at group rates. The law generally covers health plans maintained by private-sector employers with 20 or more employees, employee organizations, or state or local governments. (Montana does not have this.)

Coinsurance — A percentage of a health care provider's charge (allowed by the health insurer) for which the patient is financially responsible under the terms of the policy (usually 20% to 50%).

Community rating (pure) — A way of pricing insurance, where every policyholder or member of a large group pays the same premium, regardless of health status, age or other factors.

Consumer Access to Information—Each exchange is to maintain an Internet website through which individual consumers may obtain comparative information on participating health plans. They will also operate a toll free telephone hotline to respond to requests for assistance.

Co-Op Plan — A health insurance plan that will be sold by member-owned and operated non-profit organizations through Exchanges when they open in 2014. PPACA provides grants and loans to help Co-Op plans enter the marketplace.

Coordination of Benefits—When a patient has more than one health plan that covers their medical expenses, "coordination of benefits" rules divide the responsibility of payment between the health plans so that together they will pay up to 100%.

Co-payment — A flat-dollar amount which a patient must pay when visiting a health care provider, as opposed to "co-insurance" which is a percentage of the provider charge.

Cost-sharing — Health care provider charges for which a patient is responsible under the terms of a health plan. Common forms of cost-sharing include deductibles, coinsurance and co-payments. Balance-billed charges from out-of-network physicians are not considered cost-sharing. PPACA prohibits total cost-sharing exceed \$5,950 for an individual and \$11,900 for a family for qualified health plans certified to be sold inside the exchange. These amounts will be adjusted annually to reflect the growth of premiums.

D

Deductible — A dollar amount that a patient must pay for health care services each year before the insurer will begin paying claims under a policy. PPACA limits annual deductibles for small group policies to \$2,000 for policies that cover an individual, and \$4,000 for other policies for qualified health plans certified to be sold inside the exchange. These amounts will be adjusted annually to reflect the growth of premiums.

Defined Contribution — Defined contribution health benefit plans are employer- health plans that allow individual employees full control over their plan choice. In a defined contribution arrangement, rather than promising or providing a certain level of health benefits, the employer offers a pre-determined level of funding that the employee then controls and uses to purchase their choice of health insurance, usually in an "exchange type setting."

Disease management — A broad approach to appropriate coordination of the entire disease treatment process that often involves shifting away from more expensive inpatient and acute care to areas such as preventive medicine, patient counseling and education, and outpatient care. The process is intended to reduce health care costs and improve the quality of life for individuals by preventing or minimizing the effects of a disease, usually a chronic condition.

E

ERISA — The Employee Retirement Income Security Act of 1974 is a comprehensive and complex statute that federalizes the law of employee benefits. ERISA applies to most kinds of employee benefit plans, including plans covering health care benefits, which are called employee welfare benefit plans.

Essential Benefits — PPACA requires all health insurance plans sold after 2014 as “qualified health plans” inside the exchange to include a basic package of benefits including hospitalization, outpatient services, maternity care, prescription drugs, emergency care and preventive services among other benefits. It also places restrictions on the amount of cost-sharing that patients must pay for these services.

Exchange — PPACA creates new American Health Benefit Exchanges in each state to assist individuals and small businesses in comparing and purchasing qualified health insurance plans. Exchanges will also make initial determinations regarding who qualifies for refundable tax credits. The exchange will service as a single point of entry for individuals who qualify for tax credits and those who qualify for government programs such as HMK and Medicaid.

Exchange Authority—The entity that manages the exchange functions.

External review — The review of a health plan’s determination that a requested or provided health care service or treatment is not or was not medically necessary by a person or entity with no affiliation or connection to the health plan, (an “independent review organization” IRO). PPACA requires all non-grandfathered health plans to provide an external review process that meets minimum standards.

F

Formulary — The list of drugs covered fully or in part by a health plan.

G

Grandfathered plan — A health plan that an individual was enrolled in prior to March 23, 2010. Grandfathered plans are exempted from some changes required by PPACA. New employees may be added to employer group health plans that are grandfathered, and new family members may be added to all grandfathered plans.

Group health plan — An employee welfare benefit plan that is established or maintained by an employer or by an employee organization (such as a union), or both, that provides medical care for participants or their dependents directly or through insurance, reimbursement or otherwise.

Guaranteed issue — A requirement that health insurers sell a health insurance policy to any person who requests coverage, regardless of their health status. PPACA requires that all health insurance be sold on a guaranteed-issue basis beginning in 2014.

Guaranteed renewability — A requirement that health insurers renew coverage under a health plan except for failure to pay premium, intentional misrepresentation of a material fact or fraud. HIPAA requires that all health insurance be guaranteed renewable.

H

Health Maintenance Organization (HMO) — A type of managed care organization (health plan) that requires or creates financial incentives for a covered person to use health care providers that are managed, owned or under contract with a health insurer licensed as HMO. This does include preferred provider organization health plans.

Healthy Montana Kids (HMK) — An acronym describing the state Children's Health Insurance Program, a state health insurance plan for children. Depending on income and family size, working Montana families who do not have other health insurance may qualify for HMK.

Health Savings Account (HSA) — The Medicare bill signed by President Bush on Dec. 8, 2003 created HSAs. Individuals covered by a qualified high deductible health plan (HDHP) (and have no other first dollar coverage) are able to open an HSA on a tax preferred basis to save for future qualified medical and retiree health expenses.

High Deductible Health Plan (HDHP) — A type of health insurance plan that, compared to traditional health insurance plans, requires greater out-of-pocket spending, although premiums may be lower. In 2010, an HAS qualifying HDHP must have a deductible of at least \$1,200 for single coverage and \$2,400 for family coverage. The plan must also limit the total amount of out-of-pocket cost sharing for covered benefits each year to \$5,950 for single coverage and \$11,900 for families.

High risk pool — A state-subsidized health plan that provides coverage for individuals with pre-existing health care conditions who cannot purchase it in the private market. PPACA created a temporary federal high risk pool program, administered by the states, to provide coverage to individuals with pre-existing conditions who have been uninsured for at least 6 months. In Montana, this is known as the Montana Affordable Care Plan or MAC Plan.

HIPAA (Health Insurance Portability and Accountability Act of 1996) — The federal law enacted in 1996 which eased the “job lock” problem by making it easier for individuals to move from job to job without the risk of being unable to obtain health insurance or having to wait for coverage due to pre-existing medical conditions.

I

In-Network provider — A health care provider (such as a hospital or doctor) that is contracted to be part of the network for a managed care organization (such as an HMO or PPO). The provider agrees to the managed care organization’s rules and fee schedules in order to be part of the network and agrees not to balance bill patients for amounts beyond the agreed upon fee.

Individual mandate — A requirement that everyone maintain health insurance coverage. PPACA requires that everyone who can purchase health insurance for less than 8% of their household income do so or pay a tax penalty.

Individual market — The market for health insurance coverage offered to individuals other than in connection with a group health plan. PPACA makes numerous changes to the rules governing insurers in the individual market, including making all individual coverage “guaranteed issue” and prohibiting pre-existing condition exclusions in 2014 for all non-grandfathered health plans.

Internal review — The review of the health plan's determination that a requested or provided health care service or treatment health care service is not or was not medically necessary by an individual(s) associated with the health plan. PPACA requires all plans, including individual health plans to conduct an internal review upon request of the patient or the patient's representative. This is also known as "internal appeal" or "grievance procedure." An internal appeal rights are also required for eligibility decisions and rescission decisions.

Interstate compact — An agreement between two or more states. PPACA provides guidelines for states to enter into interstate compacts to allow health insurance policies to be approved to be sold in multiple states.

J

Job Lock — The situation where individuals remain in their current job because they have an illness or condition that may make them unable to obtain health insurance coverage if they leave that job. PPACA would eliminate job lock by prohibiting insurers from refusing to cover individuals due to health status in the individual market. HIPAA already provides this protection (since 1997) in the employer group market.

L

Lifetime limit — Many health insurance plans place dollar limits upon the claims that the insurer will pay over the course of an individual's life. PPACA prohibits lifetime limits on benefits beginning with on Sept. 23, 2010 for all health plans.

Limited Benefits Plan — A type of health plan that provides coverage for only certain specified health care services or treatments or provides coverage for health care services or treatments up to a certain dollar amount during a specified period.

M

Mandated benefit — A requirement in state or federal law that all health insurance policies provide coverage for a specific health care service, such as maternity or mental health.

Medicaid — A joint state and federal program that provides health care coverage to eligible categories of low income individuals. Rules for eligible categories (such as children, pregnant women, people with disabilities, etc), and for income and asset requirements, vary by state. Coverage is generally available to all individuals who meet these state eligibility requirements. Medicaid often pays for long-term care (such as nursing home care). PPACA extends eligibility for Medicaid to all individuals earning up to \$29,326 for a family of four (or approximately 133% of the federal poverty level). In addition, asset tests will be eliminated in 2014.

Medical Home — a health care setting that facilitates partnerships between individual patients, and their personal physicians, and when appropriate, the patient's family to provide accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care. The emphasis is on primary care, prevention and wellness in order to avoid complications due to chronic diseases.

Medical loss ratio — The percentage of health insurance premiums that are spent by the insurance company on health care services. PPACA requires that large group plans spend 85% of premiums on clinical services and other activities for the quality of care for enrollees. Small group and individual market plans must devote 80% of premiums to these purposes.

Medicare — A federal government program that provides health care coverage for all eligible individuals age 65 or older or under age 65 with a disability, regardless of income or assets. Eligible individuals can receive coverage for hospital services (Medicare Part A), medical services (Medicare Part B), and prescription drugs (Medicare Part D). Together, Medicare Part A and B are known as Original Medicare. Benefits can also be provided through a Medicare Advantage plan (Medicare Part C).

Medicare Advantage— An option Medicare beneficiaries can choose to receive most or all of their Medicare benefits through a private insurance company. Also known as Medicare Part C. Plans contract with the federal government and are required to offer at least the same benefits as original Medicare, but may follow different rules and may offer additional benefits. Unlike original Medicare, enrollees may not be covered at any health care provider that accepts Medicare, and may be required to pay higher costs if they choose an out-of-network provider or one outside of the plan’s service area.

Medicare Supplement (Medigap) Insurance — Private insurance policies that can be purchased to “fill-in the gaps” and pay for certain out-of-pocket expenses (like deductibles and coinsurance) not covered by original Medicare (Part A and Part B).

Montana Health Insurance Exchange — An internet-based information portal with three core functions: 1) provide consumers with helpful information about their health care and health care financing, 2) provide a mechanism for consumers to compare and choose a health insurance policy that meets their needs, and 3) provide a standardized electronic application and eligibility system. The exchange has many other functions, such as certifying qualified health plans, rating health plans, determining eligibility for tax credits and many other functions required by federal law.

Montana Health Insurance Exchange Board— The board of directors who will run the Montana Health Insurance Exchange Authority.

Multi-state plan — A plan, created by PPACA and overseen by the U.S. Office of Personnel Management (OPM) that will be available in every state through Exchanges beginning in 2014. These plans are provided by private health insurers who are licensed to do business in many states. The OPM will enter into contracts with private health insurers to provide at least two “national” plans in every state exchange.

N

NAIC – The National Association of Insurance Commissioners.

Navigator —An entity that serves as a navigator shall conduct public education activities to raise awareness of the availability of qualified health plans; distribute fair and impartial information concerning enrollment in qualified health plans, the availability of premium tax and cost-sharing reductions under section 1402; facilitate enrollment in qualified health plans; provide referrals to any applicable consumer assistance or health insurance for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

O

OCIIO – The Office of Consumer Information and Insurance Oversight is the division of the federal government overseeing the implementation of the provisions of the ACA.

Open enrollment period — A specified period during which individuals may enroll in a health insurance plan each year. In certain situations, such as if one has had a birth, death or divorce in their family, individuals may be allowed to enroll in a plan outside of the open enrollment period.

Out-of-network provider — A health care provider (such as a hospital or doctor) that is not contracted to be part of a health insurer's network (such as an HMO or PPO). Depending on the insurer's rules, an individual may not be covered at all or may be required to pay a higher portion of the total costs when he/she seeks care from an out-of-network provider.

Out-of-pocket limit — An annual limitation on all cost sharing for which patients are responsible under a health insurance plan. This limit does not apply to premiums, balance-billed charges from out of network health care providers or services that are not covered by the plan. PPACA requires out-of-pocket limits of \$5,950 per individual and \$11,900 per family for qualified health plans sold inside the exchange, beginning in 2014. These amounts will be adjusted annually to account for the growth of health insurance premiums.

P

Patient Protection and Affordable Care Act (PPACA or ACA) — Legislation (Public Law 111-148) signed by President Obama on March 23, 2010. Commonly referred to as the health reform law.

PHS — Policyholder Services which is a division of the Montana Office of the Commissioner of Securities and Insurance that takes insurance consumer complaints and appeals.

Pre-existing condition exclusion — The period of time that an individual receives no benefits under a health benefit plan for an illness or medical condition for which an individual received medical advice, diagnosis, care or treatment within a specified period of time prior to the date of enrollment in the health benefit plan. PPACA prohibits pre-existing condition exclusions for all plans beginning January 2014.

Premium — The periodic payment required to keep a policy in force.

Preferred Provider Organization (PPO) — A type of health plan that provides health care coverage through a network of providers. Typically the PPO requires the policyholder to pay higher costs when they seek care from an out-of-network provider. A PPO is not an HMO and cannot have a "closed" plan, whereby a covered person may ONLY receive care from a predetermined panel of providers. Some level of coverage for out-of-network providers must be provided.

Premium Reviews— The Exchanges will review the premiums that are being charged by health plans to determine whether the plan should be made available through the exchange. Insurers that have implemented rate increases determined by a state insurance department or HHS to be "unreasonable" may not be allowed to sell coverage inside the exchange.

Preventive benefits — Covered services that are intended to prevent disease or to identify disease while it is more easily treatable. PPACA requires insurers to provide coverage for certain preventive benefits without cost sharing in non-grandfathered health plans.

Program Integration— Strategic alignment of program resources which promotes efficiency and improved communication and coordination among clients, providers, and government funding agencies.

Public Small Employer — A city, town, county, or school district or an educational cooperative.

Q

Qualified employer— A public small employer or a private small employer that offers health insurance or makes health insurance available pursuant to a collective bargaining agreement to its full-time employees eligible for one or more qualified health plans offered through the SHOP exchange or at the employer's option to some or all of its part-time employees.

Qualified health plan — A health insurance policy that is sold through an Exchange. PPACA requires Exchanges to certify that qualified health plans meet minimum standards contained in the law, including standards relating to essential benefits, cost sharing, and actuarial value.

R

Rate review — Review by insurance regulators of proposed premiums and premium increases. During the rate review process, regulators will examine proposed premiums to ensure that they are sufficient to pay all claims, that they are not unreasonably high in relation to the benefits being provided, not “unjustified” and that they are not unfairly discriminatory to any individual or group of individuals.

Refundable Tax Credits providing premium assistance — Advanceable, refundable tax credits provided to low and middle income individuals and families up to 400% of federal poverty level for the purchase of qualified health insurance sold inside the exchange.

Reinsurance — Insurance purchased by insurers from other insurers or sometimes provided by a government source to limit the total loss an insurer would experience in the case of very high claims. PPACA directs states, with the assistance of HHS, to create temporary reinsurance programs to stabilize their individual markets during the implementation of health insurance reform.

Rescission — The process of voiding a health plan from its inception usually based on the grounds of material misrepresentation or omission on the application for insurance coverage that would have resulted in a different decision by the health insurer with respect to issuing coverage. PPACA prohibits rescissions except in cases of fraud or intentional misrepresentation of a material fact.

Risk adjustment — A process through which insurance plans that enroll a disproportionate number of sick individuals are reimbursed for that risk by other plans who enroll a disproportionate number of healthy individuals. PPACA requires states to provide risk adjustment for all non-grandfathered health insurance plans.

Risk corridor — A temporary provision in PPACA that requires plans whose costs are lower than anticipated to make payments into a fund that reimburses plans whose costs are higher than expected.

S

Self-insured — Group health plans may be self-insured or fully insured. A plan is self-insured (or self-funded), when the employer assumes the financial risk for providing health care benefits to its employees. A plan is fully insured when all benefits are guaranteed under a contract of insurance that transfers that risk to an insurer.

SHOP Exchange— The small business health options program within the Exchange.

Small group market — The market for health insurance coverage offered to small businesses – those with between 2 and 50 employees in most states. PPACA will broaden the market in 2014 to those with between 1 and 100 employees.

Solvency — The ability of a health insurance plan to meet all of its financial obligations. State insurance regulators carefully monitor the solvency of all health insurance plans and require corrective action if a plan's financial situation becomes hazardous. In extreme circumstances, a state may seize control of a plan that is in danger of insolvency.

Stakeholder - Person, group, or organization that has a direct or indirect stake in an organization because it can affect or be affected by the organization's actions, objectives, and policies.

State Based Systems (SBS) – The NAIC's system for tracking consumer inquiries and complaints currently used by the CSI.

W

Waiting period — A period of time that an individual must wait either after becoming employed or submitting an application for a health insurance plan before coverage